# A.7.0

# Certification Periods

**General**

This section contains guidelines for determining certification periods for CMS applications processed via a County worker at a CMS eligibility site or by a HOS worker for patients **admitted** to the hospital through the emergency room.

# A.7.1

# Certification

**A. Beginning Month**

The applicant must meet all eligibility criteria before certification. The first month of the certification period depends upon when the applicant has met all eligibility criteria. If all criteria are met for the application month, then the certification period begins that month. If all criteria are not met until the following month, the certification begins the month following the application month.

(Note: In the case of erroneous certification, refer to Item C below.)

EXAMPLE 1: The applicant is admitted to the hospital on July 28 and discharged on August 5. His net non-exempt income for July exceeds the CMS income limit, and his estimated net non-exempt income for August is below the CMS income limit. The beginning month of the certification period is August.

EXAMPLE 2: The applicant is admitted to the hospital on June 15 and discharged on June 20. In June, her net non-exempt property exceeds the CMS property limit. She has thirty days from the denial notice of action to spend the excess property down to within the limit. On July 10, she provides proof that she spent the property appropriately. The beginning month of the certification period is June.

EXAMPLE 3: The applicant received treatment at a Primary Care Clinic or Hospital Emergency Room on June 15. They had no current CMS eligibility at the time the treatment was provided but are now requesting CMS coverage for that uncertified visit. If within 30 days from the date of the uncertified visit, the patient contacts the ASO to schedule the CMS intake interview, and if all other eligibility factors are met, the beginning month of the certification period is June. If the phone call was made more than 30 days from the date of the uncertified visit, or if patient does not meet all other eligibility factors for the month of the uncertified visit, the beginning month of eligibility is the month of July. Refer to Article A, Sections 2-2.A and 2-3.A for additional information.

**B. Ending Month**

The standard certification period for applicants is six months. When a foreseeable change in circumstances that affects eligibility is expected during the certification period, the certification period may be less than six months. The last month of the certification period is the last month when all eligibility criteria are met. When the certification period is less

than six months, the worker must state the reason in the case record comments and on the NOA that certifies CMS.

EXAMPLE 1: The applicant's net non-exempt income is below the income limit in the month of application, but is expected to exceed the income limit the following month. The certification period is one month.

EXAMPLE 2: The applicant lives in San Diego County in the month of application, but says he is moving out of county the next month. The certification period is one month.

EXAMPLE 3: The applicant's INS document expires in three months. The certification period is three months.

EXAMPLE 4: The applicant needs to see a doctor or fill a prescription within 72 hours and is unable to get a bank statement. The worker can call the bank to verify the account balance and certify one month. Upon receipt of the bank statement, the worker may extend the certification period.

EXAMPLE 5: The applicant applies in the month of May and is receiving bi-weekly gross earned income of $595. Based on the paydays, the applicant will receive two paychecks per month for the period of May through August and will get a third paycheck in September. The gross income totals $1,289.36 when converted to a monthly amount using the 2.167 factor. The net non-exempt income is $1,199.36 after deducting the $90 standard work expense, which puts the applicant over the CMS MNL. The worker will re-compute eligibility using the actual income of $595 x 2 paydays in the month. This equals a net countable income of $1,100 after deducting the $90. The worker will certify for the months of May through August.

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**C. Erroneous Certification Required Actions**

Upon the discovery of an error resulting in erroneous certification of CMS, the worker must immediately contact their Supervisor. Depending on when the error is discovered, the worker will immediately take action as instructed under 1 or 2 below. The erroneous certification details must be recorded in the case narrative.

**Note:** This process will remain the same until CMS IT system is upgraded.

1. If the error was discovered within 30 calendar days of the erroneous action, **and** based on worker clearance of IDX, no claims have been received, the worker shall rescind the

certification back to the original application date by taking the following actions:

a) Issue Notice of Action CMS CMS-34R to the applicant, informing them of the error and the rescission.
b) Send a CMS-4 to the CMS Program Administrative Services Organization (ASO) at O557-B noting the change in eligibility status and the reason for the error.

2. If the error is discovered more than 30 calendar days after the erroneous action or within 30 calendar days but worker clearance of IDX reflects claims submitted for dates of service within the erroneous certification period, the worker shall discontinue CMS eligibility by taking the following actions:

a) Issue Notice of Action CMS CMS-34R to the applicant, informing them of the error and date of discontinuance.
b) Discontinue CMS benefits effective immediately.
c) Send a CMS-4 to the CMS Program ASO at O557-B noting the change in eligibility status and the reason for the error.
d) Send the case to the CMS Third Party Liability (TPL) Program Specialist (PS) at 0557-A for additional action including overpayment assessment and collections, as applicable.

**NOTE:** The TPL PS shall determine if additional actions are required, on a case by case basis, and as directed by the CMS Sr. Program Manager. In some cases, the provider may be liable for repayment of claims paid erroneously.

# A.7.2

# Recertification

**General**

Recertification is a determination that a beneficiary continues to meet the CMS eligibility criteria and has not had a break in aid of more than one (1) month. CMS has two standards for recertification: standard and chronic. Recertification information shall be recorded in the case narrative.

**A. Recertification Eligibility Appointments**

All CMS beneficiaries who wish to recertify must submit a completed CMS Medical/Dental Need Form (HHSA:CMS-127) to the ASO prior to requesting an eligibility appointment. The beneficiary will not be given an eligibility appointment if the completed form has not been received by the ASO.

**EXCEPTION:**
A CMS-127 is **not** needed when:

1) AmeriChoice has an approved Treatment Authorization Request (TAR) waiting to be used. An approved TAR is verification of a medical need.
2) A CMS inpatient (as identified in the Hospital Outstationed Services (HOS) Policy and Procedures manual) has been hospitalized and referred to HOS. The hospital admission is verification of a medical need.
3) Beneficiaries identified by AmeriChoice as having a chronic medical condition by the "CHRONIC" indicator on IDX Eligibility Enrollment Summary Screen.
4) Share of Cost has been met in the last month of certification.
5) A CMS beneficiary has been treated in the emergency room and calls the CMS Eligibility Appointment Line (ASO) within 30 days of the emergency room visit to schedule an intake interview. The emergency room visit is verification of a medical need.

A CMS-127 **is** needed when:

1. Requesting a recertification appointment.
2. Requesting a reapplication appointment within 6 months of their previous CMS certification expiring.

**B. Non-Chronics**

Non-chronics may be recertified for up to six months.

**C. Chronics**

Chronics may be recertified up to twelve months. Chronics are those beneficiaries who have been identified by the ASO as having a chronic medical condition by entering a "**CHRONIC**" indicator on the IDX Eligibility Enrollment Summary Screen. Before recertifying, the worker **must** look for the "**CHRONIC**" indicator. CMS beneficiaries with the "**CHRONIC**" indicator, who fail to recertify timely, may still be certified for a 12-month period if they apply no later than two months from the last month of CMS eligibility and meet all eligibility requirements.

**D. Exceptions**

CMS beneficiaries, both chronic and non-chronic, are to be recertified for the standard period with the following exceptions:

When a beneficiary must comply with program requirements or has a foreseeable change in circumstances that affects eligibility during the recertification period, the recertification period may be less than the standard. When the recertification period is less than the standard, the worker must state the reason in the comment section of the CMS IT automated NOA that certifies CMS and in the case narrative.

EXAMPLE 1: A CMS beneficiary with the "CHRONIC" indicator on IDX claims or is identified as having a disabling condition that may potentially link him/her to Medi-Cal. The worker refers the beneficiary to apply for Medi-Cal noting "Referred to MC DED" in the case narrative. This example also applies to a non-chronic CMS beneficiary.

EXAMPLE 2: A CMS beneficiary with the "CHRONIC" indicator on IDX will turn 65 years old in nine months. The worker will recertify for eight months and note "Turns 65 month/year" in the comment section of the enrollment form. In this example, if the beneficiary is a non-chronic, the worker will recertify for six months and note "Turns 65 month/year" in the case narrative.

EXAMPLE 3: A CMS beneficiary with a "CHRONIC" indicator on IDX has a certification period that ends on January 31, 2001 and fails to recertify in February. He/she reapplies in March 2001 and meets all eligibility requirements and has no foreseeable changes that may affect eligibility. CMS is to be certified for 12 months. This information must be recorded in the case narrative.

# A.7.3

# CMS Program Instructions For A Short Certification

**General**

CMS staff routinely identifies patients who are required to comply with program regulations. Based on individual case situations, CMS Program staff instructs the worker to certify the patient for a shorter period. The worker certifies for the appropriate period and informs the patient on the granting NOA that in any subsequent application filed within one (1) year of the current application date or upon recertification, they must prove that they have complied with the action requested. The worker must state the reason for the shorter certification period in the case narrative.

# A.7.4

# General Relief (GR) Recipients

**General**

GR recipients are automatically eligible to CMS without having to complete a CMS application; however, they are not automatically enrolled into the CMS IT System and IDX. See the GR Program Guide for details.

# A.7.5

# Parents Potentially Linked To CalWORKs or Medi-Cal

**General**

Parents of minor children, who are disabled, incapacitated, or unemployed, must be referred to CalWORKS or Medi-Cal. Clinic workers evaluate linkage based upon the definitions in MPG Article 5, Section 2, refer the parent using form HHSA: CMS-5 and deny CMS. If the parent is denied CalWORKS or Medi-Cal because he or she is not linked and returns to re-apply for CMS, the worker must review the denial reason. If the denial appears correct, the worker will certify for six months. The worker may, upon request of the parent, rescind the CMS denial to the original application date by processing the application through the CMS IT System. If the denial reason is questionable, the worker must advise the parent to appeal and may certify for up to three months. This allows the parent enough time to appeal the denial while getting necessary medical treatment.

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# A.7.6

# Applicants Referred To Another Resource

**General**

Applicants who are potentially eligible to another resource such as, but not limited to unconditionally available income, disability based Medi-Cal or Social Security Disability, must apply for and accept that resource. CMS beneficiaries potentially eligible to another resource who are denied for no show, failure to provide or other reasons for not cooperating in obtaining the resource are considered non-compliant and not eligible to CMS until they fully comply. If the applicant is no longer potentially eligible to another resource, then the worker must verify and document the reason in the case narrative.

The County has contracted with the Legal Aid Society of San Diego, Inc. to provide SSI advocacy services for General Relief (GR) recipients, Board & Care Payment Program (B&C), Cash Assistance Program for Immigrants (CAPI) and CMS customers who may be eligible for Supplemental Security Income (SSI). CMS requires some patients to apply for disability linked Medi-Cal through Disability Determination Services Division (DDSD) a condition for eligibility for CMS and generally follows Medi-Cal regulations regarding applying for unconditionally available income. Medi-Cal does not consider SSI unconditionally available income because it is viewed as Public Assistance. A CMS applicant who has been identified as potentially eligible to Medi-Cal or SSI may be referred to the Legal Aid SSI Advocate for assistance in applying for or reapplying for SSI benefits or assisting with the process of filling an SSDI/SSI appeal. Worker will either mail or fax form HHSA:CMS-2 to the Legal Aid SSI Advocate and notes in the comment section of the CMS IT system, “SSI Advocacy Services Referred.”

# A.7.7

# Retroactive Coverage

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| **General** | CMS does not pay for medical expenses incurred before the application month. |

# A.7.8

# Hospital Admission During The Certification Period

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| **General** | Emergency hospitalizations and scheduled admissions that occur during the certification period are covered. See Article A, Section 2.E. |

# A.7.9

# Changes and Information Reported During Certification Period

**A. Informing Letter**

As a general rule, once a certification period has been approved, CMS eligibility continues until the end of the certification period or until the beneficiary becomes eligible to full scope Medi-Cal benefits before the certification period ends.

***Exception:*** Erroneous certifications (refer to Article A, Section 7-1-D for additional information).

When the worker receives information or becomes aware of a change that may affect CMS eligibility, the worker shall review the case and determine whether clarifying information is needed. If additional information is required, the worker must send an informing letter, HHSA: CMS-34, to the beneficiary. This letter explains how the information may affect CMS eligibility and the beneficiary may need to make other payment arrangements with health care providers before the certification period ends. The letter informs the beneficiary of any additional verification that must be provided and provides a specific due date for the requested verification. It also informs the beneficiary that they may apply for CMS at any time if they have a change in circumstances. If necessary, the worker also submits form HHSA: CMS-4 or 14-10 HHSA to the CMS Program ASO at O557-B to update the IDX comments screen with the reported information. When any of the above information takes place, it must be recorded in the case narrative.

**NOTE:** This process will remain the same until CMS IT System is upgraded.

**B. Fraud Referral**

If information is received after a case is granted that would have made the applicant ineligible to CMS at the initial application, the worker follows the instructions for fraud referrals in MPG Article A, Section 11 and records details in the case narrative.